BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

GREGORY L. WHITFIELD	)	
Claimant	)	
VS.	)	
	)	Docket No. 1,058,746
LANSING STATE PENITENTIARY	)	
Respondent	)	
AND	)	
	)	
STATE SELF-INSURANCE FUND	)	
Insurance Carrier	)	

ORDER

Claimant requested review of the April 29, 2014, Award by Administrative Law Judge (ALJ) William G. Belden. The Board heard oral argument on September 9, 2014, in Lenexa, Kansas.

APPEARANCES

George H. Pearson, III, of Topeka, Kansas, appeared for the claimant. Nathan D. Burghart, of Lawrence, Kansas, appeared for respondent and its insurance carrier.

RECORD AND STIPULATIONS

The Board has considered the record and adopted the stipulations listed in the Award. At the oral argument to the Board, the parties advised the issue dealing with the admissibility of the medical reports of board certified orthopedic surgeon Steven T. Joyce, M.D., was no longer in dispute. The parties further stipulated the Board could utilize the AMA *Guides*, 4th Edition[1] (Guides) while deciding this matter.

[1] American Medical Ass'n, *Guides to the Evaluation of Permanent Impairment* (4th ed.). All references are to the 4th edition unless otherwise noted.

ISSUES

The ALJ adopted the findings and conclusions of the court-ordered physician, board certified orthopedic surgeon Steven T. Joyce, M.D., finding Dr. Joyce's 7 percent permanent partial impairment of function rating more closely approximates claimant's impairment of function of the left shoulder, particularly in light of claimant's ability to work without restriction for over a year and one-half. Noting the unauthorized medical allowance had apparently not been utilized, or at least not paid, the ALJ ordered the $500.00 unauthorized medical allowance be left open to be paid either by agreement or upon application and hearing before the Director. Future medical treatment was also to be later awarded either by agreement of the parties or upon application and hearing before the Director.

Claimant appeals arguing there is no basis in the record for Dr. Joyce's rating or how he arrived at it. Claimant contends Dr. Prostic's rating is superior as it was shown to be in conformance with the *Guides*. Therefore, claimant should be awarded a 22 percent impairment of the left upper extremity at the shoulder.

Respondent argues the ALJ should be affirmed as it was objectively reasonable to rely on the neutral physician's rating after concluding it was more appropriate. Respondent also argues that claimant had the right, at the suggestion of the ALJ, to depose Dr. Joyce to confirm the exact manner in which he arrived at his opinion under the *Guides* and did not do so.

The issues listed by claimant on appeal are as follows:

"(1) Nature and Extent of Disability;

(2) Whether Dr. Stephen Joyce's impairment rating is admissible without foundation? [Withdrawn at oral argument to the Board.]

(3) Whether the Administrative Law Judge properly decided the case by accepting the testimony of nontestifying (Dr. Stephen Joyce) doctor over that of a testifying doctor (Dr. Edward Prostic)."[2]

FINDINGS OF FACT

Claimant began working for respondent in August 1999, as a Correction Specialist I, second in command over the medium or minimum security compound. Claimant supervised 80-90 inmates eating dinner, and two other officers who assisted him in supervising the inmates. Claimant was a full-time employee.

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[2] Application for review at 1 (filed May 5, 2014).

On March 22, 2011, while in the middle of the evening meal, a fight started outside of the dining area. Claimant ran out to the area and found three inmates fighting. He grabbed one of them to pull him back. However, when claimant grasped the 6 foot 6 inch, 295 pound inmate, the inmate bounced claimant backwards into a concrete wall and windows. He then grabbed claimant's thumb, yanked it and threw claimant to the ground. Claimant was able to get up and reengage the inmate and, within 20 or 30 seconds, two more officers arrived and helped subdue the inmate and break up the fight.

Claimant testified his left thumb was wrenched backwards. He iced his thumb that night. At the time, he didn't realize he had injured his left shoulder during the fight, but the next morning he woke up with a stiff shoulder. When claimant went to hug his wife he realized he was unable to raise his arm up to a horizontal position or above his head and he couldn't put pressure on his shoulder.

Claimant reported his shoulder injury to human resources and an appointment was set up at Lawrence Memorial for x-rays. On March 23, 2011, claimant was examined by Dr. Reynolds who ordered an MRI. The April 4, 2011, MRI revealed a full-thickness rotator cuff tear to the supraspintus tendon and acromioclavicular arthropathy with a small os acromiale. Claimant met with Chris Fevurly, M.D., for follow-up and was referred to Dr. Brett E. Wallace[3] for left shoulder surgery. Dr. Wallace repaired claimant's rotator cuff on May 25, 2011, performing an arthroscopic subacromial decompression, excision of an os acromiale, excision of the lateral clavicle and mini open repair of the rotator cuff. Claimant testified that while undergoing physical therapy in September 2011, he experienced a "pop" in his shoulder and continued to have pain since that time. In late October 2011, claimant returned to work for respondent without restrictions. Claimant testified he was concerned the pain and weakness he felt in his shoulder would impair his ability to defend himself and perform his job duties in future altercations with inmates.

Claimant retired from his job with respondent on June 28, 2013, for a variety of reasons. The main reason he retired was the loss of strength in his left shoulder and arm caused him to feel he could not protect himself or his fellow officers should the need arise. Claimant also voiced concern over the morning numbness in his left shoulder. He testified this numbness goes away as he starts to move around in the morning, but first thing in the morning he could slam his arm on a table and not feel it. He testified he could sleep on his left side or his back and still have the numbness. Claimant's left arm also goes numb when he is doing stuff around the house and he has to stop what he's doing to get the blood circulating again. However, 90 percent of the time the numbness in his left arm occurs when he is laying down. Claimant's shoulder has continued to get worse since he stopped working. He denies any other accidents to his shoulder after March 2011.

[3] Also identified in this record as Dr. Greg Wallace.

Claimant's thumb problem resolved, but his shoulder problem did not. Claimant received some relief from surgery, but it is still not "correct".[4] Post surgery, claimant is unable to raise his shoulder past a horizontal position or his arm above his shoulder. After left shoulder surgery, claimant had a new symptom of numbness running from the left shoulder down into his arm and into his hand. He testified his shoulder feels like it would feel if one put his hand in a vice and twisted.

At the request of his attorney, claimant met with board certified orthopedic surgeon Edward J. Prostic, M.D., for evaluation on January 17, 2012. Claimant's post-injury MRI of the left shoulder revealed a full thickness tear of the supraspinatus. Claimant reported constant discomfort in his shoulder and an inability to sleep on his left side. Claimant also had problems flexing and abducting, and experienced clicking and popping with continuous weakness. He had difficulties with some tasks as simple as turning his steering wheel left-handed.

Dr. Prostic examined claimant and found significant tenderness anteriorly, painful abducting with internal rotation, mild restriction of internal rotation, mild creptius, moderate weakness of flexion and rotation, but severe weakness of abduction with internal rotation. AP projections of the left shoulder revealed evidence of subacromial decompression and excision of the lateral clavicle and significant demineralization of the greater tuberosity glenohumeral arthropathy. Dr. Prostic found the arthropathy to be preexisting, perhaps aggravated.

Dr. Prostic opined claimant had a poor result from rotator cuff surgery. He recommended another MRI to check continuity of the repair and, if claimant continues to have significant tearing, a repeat surgery should be offered.

Claimant met with orthopedic surgeon Steven T. Joyce, M.D., for a court-ordered Independent Medical Evaluation (IME), on September 24, 2012. Dr. Joyce was asked to evaluate claimant, provide treatment recommendations, address maximum medical improvement (MMI) and provide a rating if appropriate.

Dr. Joyce examined claimant's right shoulder and found full range of motion and 5 out of 5 in strength. The left shoulder had full range of motion in flexion, but limited to 90 degrees of active abduction, internal and external rotation were at tabletop passively in the supine position, abduction could be performed passively to 160 degrees, O'Brien's test was slightly positive, speed test was negative, strength testing with abduction and internal rotation was 4+/5 and external rotation strength was 4+/5. X-rays revealed a distal claviculectomy of 1 cm. There was noted a removal of the os acromiale, the humeral head did not ride proximally and there was no significant glenohumeral arthropathy.

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[4] R.H. Trans. at 26.

Dr. Joyce opined claimant had a probable recurrent left shoulder rotator cuff tear. He felt it would not be appropriate to provide a rating for MMI until the results of the MRI arthrogram are known.

Claimant met with Dr. Joyce for another IME on November 13, 2012. Dr. Joyce was asked to evaluate claimant, provide treatment recommendations, address MMI and provide a rating if appropriate. Claimant presented with the same left shoulder complaints. Dr. Joyce's examination findings were the same as they were in September 2012.

Dr. Joyce opined claimant had a probable recurrent left shoulder rotator cuff tear. The MRI of the left shoulder with ultra-articular contrast was performed on November 9, 2012, and revealed thinning of the rotator cuff supraspinatus and infraspinatus tendons. Claimant was allowed to return to regular duty. Dr. Joyce assigned a 7 percent permanent partial impairment to the left upper extremity (4 percent whole person), pursuant to the *Guides*.

On April 9, 2013, claimant again met with Dr. Prostic. At this time, claimant continued to have left shoulder pain with difficulty sleeping on his left side, numbness of his left arm down into his fingers and some weakness and loss of motion. Claimant's posture sitting, standing and walking was satisfactory. Claimant's left arm was a half-inch smaller in circumference than his right arm. Claimant had a 20 degree loss of flexion, abduction and internal rotation, but there was no crepitus or instability. There was moderate weakness of flexion and abduction and somewhat greater weakness of internal and external rotation as comparted to the dominant right side. X-rays of the left shoulder revealed the appearance of mild joint space narrowing and a small osteophyte at the inferior humeral head. Dr. Prostic testified that these x-ray findings may have been caused or contributed to by the March 22, 2011, work accident.

Dr. Prostic testified claimant reported numbness and tingling after sleeping. Dr. Prostic continued to opine that on or about March 22, 2011, claimant sustained injury to his left shoulder with tearing of the rotator cuff. He went on to state there appeared to be developing osteoarthritis of the shoulder. He felt additional treatment would be required in the future. Therefore, should claimant settle, he should leave medical benefits open.

Dr. Prostic indicated there was no physical basis recorded documenting claimant's reported numbness and tingling. He testified the typical source of numbness and tingling when you sleep on the side is carpal tunnel syndrome, but he did not make that diagnosis with claimant. Claimant's tests for cervical radiculopathy, thoracic outlet syndrome and carpal tunnel syndrome were all negative. Dr. Prostic indicated he was not able to link claimant's left upper extremity numbness and tingling to the March 22, 2011, work altercation because he didn't have a diagnosis for the particular incident. He couldn't give a cause for claimant's complaints of numbness and tingling. Dr. Prostic did not assign any impairment for the neurological symptoms and did not suggest any further investigation or treatment for it.

When asked about a final diagnosis, Dr. Prostic testified to post operative rotator cuff repair and excision of the lateral clavicle, early osteoarthritis of the shoulder and residuals of the rotator cuff repair. He testified that since claimant is developing osteoarthritis in his shoulder, he may be a surgical candidate in the future. He also indicated because claimant went from using pain medication when they first met to not using any pain medication at time of their second meeting, that was an indication claimant's symptoms were improving. Claimant's creptius was gone from the first to second exams, his range of motion was improved, the clicking and popping sensations he had at the first exam were gone and his instability and signs of impingement were also gone. Claimant continued to have issues with range of motion, pain and weakness. Dr. Prostic did note claimant had improved between his examinations. Claimant had reduced his use of pain medication and there was no instability or impingement signs at the second exam. Additionally, claimant's range of motion had improved.

Dr. Prostic assigned a 22 percent permanent partial impairment to the left upper extremity (10 percent for the distal clavicle excision; 3 percent for loss of range of motion; and 9 percent for weakness), based on the *Guides.* He indicated there was no way a 7 percent permanent partial impairment to the left upper extremity could be in conformance with the *Guides* for claimant's extensive shoulder surgery. Exhibit 4 to Dr. Prostic's deposition includes sections of the *Guides*. Table 27 on page 3/61 appears to indicate a distal clavicle resection results in a 10 percent impairment to the upper extremity.

Dr. Prostic acknowledged the only diagnosis which could be related to the work accident would be the rotator cuff tear. The other conditions were either congenital or preexisting. Questions were raised at Dr. Prostic's deposition as to whether the 9 percent impairment given for weakness involved the shoulder or a hand grip and pinch assessment. The section used by the doctor was pertinent to the hand and not necessarily to the shoulder. Dr. Prostic acknowledged the 4th ed. of the *Guides* did not contain a provision allowing a rating for weakness or loss of strength to the shoulder without a neurological source. In support of his opinion, Dr. Prostic noted the *Guides* are intended as guidelines and may not contain ratings for every injury.

Dr. Prostic did not assign restrictions, stating that if he did claimant would have lost his job. Claimant was working full-time with no restrictions when he met with Dr. Prostic.

Claimant has not seen a physician regarding his left shoulder since the October 22, 2013, Regular Hearing. Dr. Joyce told claimant there was not enough tendon or muscle left in the shoulder to fix claimant's shoulder. Claimant testified he was also told this by Dr. Prostic. Claimant testified his shoulders problems are worse since the October 22, 2013, Regular Hearing.

PRINCIPLES OF LAW AND ANALYSIS

K.S.A. 2010 Supp. 44-501(a) states:

> (a) If in any employment to which the workers compensation act applies, personal injury by accident arising out of and in the course of employment is caused to an employee, the employer shall be liable to pay compensation to the employee in accordance with the provisions of the workers compensation act. In proceedings under the workers compensation act, the burden of proof shall be on the claimant to establish the claimant's right to an award of compensation and to prove the various conditions on which the claimant's right depends. In determining whether the claimant has satisfied this burden of proof, the trier of fact shall consider the whole record.

K.S.A. 2010 Supp. 44-508(g) states:

> (g) ''Burden of proof'' means the burden of a party to persuade the trier of facts by a preponderance of the credible evidence that such party's position on an issue is more probably true than not true on the basis of the whole record.

It is not disputed claimant suffered a work-related accident which led to significant shoulder problems. The dispute centers around the impairment to which this claimant would be entitled as the result of that accident and resulting injuries. Claimant has withdrawn his objection to the admissibility of the records of Dr. Joyce, but still disputes the weight to be given Dr. Joyce's opinions.

K.S.A. 44-510e Furse 2000 defines functional impairment as:

> (a) . . . the extent, expressed as a percentage, of the loss of a portion of the total physiological capabilities of the human body as established by competent medical evidence and based on the fourth edition of the American Medical Association Guides to the Evaluation of Permanent Impairment, if the impairment is contained therein.

Dr. Joyce assessed claimant a 7 percent functional impairment to the upper extremity at the shoulder, based upon the *Guides* However, as noted by Dr. Prostic, the *Guides* appear to allow 10 percent impairment for a distal clavicle resection. On the other hand, Dr. Prostic acknowledged the 9 percent impairment to the upper extremity at the shoulder for weakness appears to utilize the section of the *Guides* involving the hand and grip strength. There does not appear to be a *Guides* section for rating the shoulder for loss of strength. Dr. Prostic testified both the 5th and 6th editions of the *Guides* allow for such a rating, but the Kansas Legislature has limited the use of the *Guides* to the 4th ed. for this date of accident.

Both Drs. Joyce and Prostic noted claimant had left upper extremity strength loss. Dr. Prostic documented claimant's loss of muscle bulk in the left arm as compared to his right arm. Less muscle would seem to go hand-in-hand with less strength. Respondent agreed at oral argument that claimant has left arm strength loss, but argued strength loss is not rateable under the *Guides* unless such strength deficit is neurologically based.

However, a physician may use his judgment to address impairments not addressed by the *Guides*.[5] The omission or failure of the *Guides* to account for a loss of upper extremity strength loss, except for strength loss caused by neurological reasons, does not mean claimant's documented strength loss warrants no finding of permanent impairment. Where the *Guides* do not address an impairment, the rating physician may use his or her medical judgment. That is precisely what happened here. Dr. Prostic provided claimant a rating for left upper strength loss that was not otherwise accounted for under the *Guides*. Dr. Prostic indicated he could use Table 15 or Table 34 as a basis for the loss of strength rating. Dr. Prostic did not conclude claimant had strength loss or impairment due to a neurological injury, but was rather using such tables from the *Guides* by analogy: claimant's permanent strength loss is comparable to strength loss noted in such tables. Dr. Prostic did not rate claimant as having impairment due to left upper extremity strength loss. Dr. Prostic testified he was not doing so.

Both opinions rate the shoulder after the work accident and resulting surgery. Neither rating opinion appears to be perfect. Both rating opinions raise questions in the mind of the Board. As such, the Board finds neither should be exclusively adopted, nor should either be outright rejected. As such, the Board finds an average of the two opinions to be the most accurate assessment of claimant's actual functional loss from the March 22, 2011, work-related accident and resulting injuries.

In averaging the two ratings, the Board finds claimant has suffered a 14.5 percent functional impairment to his left shoulder as the result of the accident on March 22, 2011. The Award of the ALJ will be modified accordingly. The remainder of the Award is affirmed insofar as it does not contradict the findings and conclusions contained herein.

CONCLUSIONS

Having reviewed the entire evidentiary file contained herein, the Board finds the Award of the ALJ should be modified to award claimant a functional impairment of 14.5 percent to the left upper extremity at the level of the shoulder. In all other regards, the Award of the ALJ is affirmed insofar as it does not contradict the findings and conclusions contained herein.

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[5] See K.S.A. 44-510e(a); see also *Smith v. Sophie's Catering & Deli Inc.*, No. 99,713, 202 P.3d 108 (Kansas Court of Appeals unpublished opinion filed Mar. 6, 2009), *publication denied* Nov. 5, 2010, and *Kinser v. Topeka Tree Care*, No. 1,014,332, 2006 WL 2632002 (Kan. WCAB Aug. 1, 2006).

AWARD

WHEREFORE, it is the finding, decision and order of the Board that the Award of Administrative Law Judge William G. Belden dated April 29, 2014, is modified to award claimant a 14.5 percent functional impairment to the left upper extremity at the level of the shoulder. In all other regards, the Award is affirmed insofar as it does not contradict the findings and conclusions contained herein.

As of the date of this award claimant is entitled to 22.57 weeks of temporary total disability compensation at the weekly rate of $518.98, totaling $11,713.38, followed by 29.35 weeks of permanent partial disability at the weekly rate of $518.98, totaling $15,232.06 for a total award of $26,945.44, for a 14.5 percent permanent partial functional impairment at the level of the shoulder, all of which is due and owing, and ordered paid in one lump sum, minus any amounts previously paid.

IT IS SO ORDERED.

Dated this _____ day of October, 2014.

_____
BOARD MEMBER

_____
BOARD MEMBER

_____
BOARD MEMBER

c: George H. Pearson, III, Attorney for Claimant
georgepearsonlaw@sbcglobal.net
dfloyd.georgepearsonlaw@yahoo.com

Nathan D. Burghart, Attorney for Respondent and its Insurance Carrier
nate@burghartlaw.com
stacey@burghartlaw.com

William G. Belden, Administrative Law Judge